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Date 2/13/01

Number of pages 22 (including cover page)

to: Name U.S. Patent Office

Company P.T.O.

Telephone 703 305 9285

Fax 703 308 6916

from: Name Patrick Smith

Company 2901 Beverly Blvd

Telephone L A CA 90057

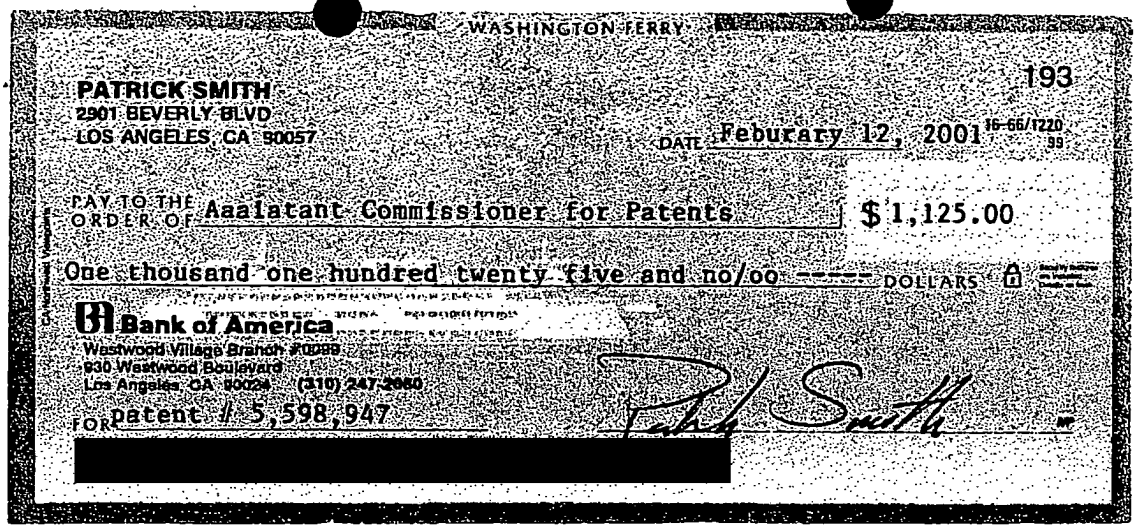
Fax

Comments

FAX RECEIVED

FEB 13 2001

PETITIONS OFFICE



PATRICK SMITH
2901 BEVERLY BLVD
LOS ANGELES, CA 90057

WASHINGTON FERRY

193

DATE Feburary 12, 2001 16-66/1220 99

PAY TO THE ORDER OF Aaalatant Commissioner for Patents $1,125.00

One thousand one hundred twenty five and no/oo ----- DOLLARS

Bank of America
Westwood Village Branch #0289
930 Westwood Boulevard
Los Angeles, CA 90024 (310) 247-2960

FOR Patent # 5,598,947

[redacted]

Pat Smith

Petition Section
Patent # 5,598,947
Patrick Smith

Please type a plus sign (+) inside this box ☐

PTO/SB/45 (01-01)
Approved for use through 12/31/2002. OMB 0651-0016
U.S. Patent and Trademark Office; U.S. DEPARTMENT OF COMMERCE

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FAX RECEIVED
FEB 13 2001
PETITIONS OFFICE

MAINTENANCE FEE TRANSMITTAL FORM

Address to:
Assistant Commissioner for Patents
Box M Fee
Washington, D.C. 20231

I hereby certify that this correspondence is being deposited with the United States Postal Service with sufficient postage as first class mail in an envelope addressed to "Assistant Commissioner for Patents, Box M Fee, Washington D.C. 20231" on Feburary 12, 2001.

Signature _____.

Typed or printed name Patrick Smith patentee.

Enclosed herewith is the payment of the maintenance fee(s) for the listed patent(s).

1. [XX] A check for the amount of $1,125.00 for the full payment of the maintenance fee(s) and any necessary surcharge on the following patents is enclosed.
2. ☐ The Commissioner is hereby authorized to charge $_____ to cover the payment of the fee(s) indicated below to Deposit Account No._____.
3. ☐ The Commissioner is hereby authorized to charge any deficiency in the payment of the required fee(s) or credit any overpayment to Deposit Account No._____.
4. ☐ Payment by credit card. Form PTO-2038 is attached.

*Information required by 37 CFR 1.366(c) (columns 1 & 4). Information requested under 37 CFR 1.366(d) (columns 2, 3, 5, & 6)

Item	Patent Number*	Maintenance Fee Amount (37 CFR 1.20 (e)-(g))	Surcharge Amount (37 CFR 1.20 (h)-(i))	U.S. Application Number* [06/555,555]	Payment Year 5			Small Entity? **
	1	2	3	4	3.5 yrs	7.5 yrs	11.5 yrs	6
1	5,598,947	$425.00	$700.00		X			X
2								
3								
4								
5								
6								
Subtotals__Columns 2 & 3								
Total Payment								

☐ _____additional sheets attached for listing additional patents.

WARNING: Information on this form may become public. Credit card information should not be included on this form. Provide credit card information and authorization on PTO-2038.

Respectfully submitted***:

Customer's name: Patrick Smith

Telephone: no phone

Fax:

Customer's Signature: Patrick Smith

Note. *All correspondence will be forwarded to the "Fee Address" or to the "Correspondence Address" if no "Fee Address" has been provided. 37 CFR 1.363.

**Payment of small entity fee is appropriate if small entity status still exists, see 37 CFR 1.27(g). To establish small entity status or to change status from small to large entity, note the requirements of 37 CFR 1.27 and 1.33(b).

***WHERE MAINTENANCE FEE PAYMENTS ARE TO BE MADE BY AUTHORIZATION TO CHARGE A DEPOSIT ACCOUNT, BOTH CUSTOMER'S NAME AND SIGNATURE ARE REQUIRED.

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PETITIONS OFFICE

#19

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PETITION TO ACCEPT UNAVOIDABLY DELAYED PAYMENT OF MAINTENANCE FEE IN AN EXPIRED PATENT (37 CFR 1.378(b))

Docket Number (Optional)

Mail to: Assistant Commissioner for Patents
Box DAC
Washington, D.C. 20231

NOTE: If information or assistance is needed in completing this form, please contact Petitions Information at (703) 305-9282.

Patent No. 5,598,947 Application Number 08/377,449

Issue Date Feb 4, 1997 Filing Date _____

CAUTION: Maintenance fee (and surcharge, if any) payment must correctly identify: (1) the patent number (or reissue patent number, if a reissue) and (2) the application number of the actual U.S. application (or reissue application) leading to issuance of that patent to ensure the fee(s) is/are associated with the correct patent. 37 CFR 1.366 (c) and (d).

Also complete the following information, if applicable

The above-identified patent:

☐ is a reissue of original Patent No._____, original issue date _____; original application number _____, original filing date _____.

☐ resulted from the entry into the U.S. under 35 U.S.C. 371 of international application _____filed on_____.

CERTIFICATE OF MAILING (37 CFR 1.8(a))

I hereby certify that this paper (along with any paper referred to as being attached or enclosed) is being deposited with the United States Postal Service on the date shown below with sufficient postage as first class mail in an envelope addressed to the Assistant Commissioner for Patents, Box DAC, Washington, D.C. 20231.

Feb 12, 2001
Date

Signature

Patrick Smith patentee
Typed or printed name of person signing Certificate

PTO/SB/65 (10-00)
Approved for use through 12/31/2002. OMB 0651-0016
U.S. Patent and Trademark Office; U.S. DEPARTMENT OF COMMERCE

1. SMALL ENTITY

☒ XX Patentee claims, or has previously claimed, small entity status. See 37 CFR 1.27.

2. LOSS OF ENTITLEMENT TO SMALL ENTITY STATUS

☐ Patentee is no longer entitled to small entity status. See 37 CFR 1.27(g).

3. MAINTENANCE FEE (37 CFR 1.20(e)-(g))

The appropriate maintenance fee must be submitted with this petition, unless it was paid earlier.

NOT Small Entity Amount Fee (Code)	Small Entity Amount Fee (Code)	
☐ $_____ 3 1/2 yr fee (183)	☐ $_____ 3 1/2 yr fee (283)	$425.
☐ $_____ 7 1/2 yr fee (184)	☐ $_____ 7 1/2 yr fee (284)	$700.
☐ $_____ 11 1/2 yr fee (185)	☐ $_____ 11 1/2 yr fee (285)	$1,125

MAINTENANCE FEE BEING SUBMITTED $_____

4. SURCHARGE

The surcharge required by 37 CFR 1.20(i)(1) of $_____ (Fee Code 187) must be paid as a condition of accepting unavoidably delayed payment of the maintenance fee. $700. ?

SURCHARGE BEING SUBMITTED $_____

5. MANNER OF PAYMENT

☐ Enclosed is a check for the sum of $ 1,125.00

☐ Please charge Deposit Account No._____ the sum of $_____. A duplicate copy of this authorization is attached.

☐ Payment by credit card. Form PTO-2038 is attached.

6. AUTHORIZATION TO CHARGE ANY FEE DEFICIENCY

☐ The Commissioner is hereby authorized to charge any maintenance fee, surcharge or petition fee deficiency to Deposit Account No. _____. A duplicate copy of this authorization is attached.

I was told to pay $425. plus $700. for unavoidably delayed payment of maintenance fee.

PTO/SB/65 (10-00)
Approved for use through 12/31/2002. OMB 0651-0016
U.S. Patent and Trademark Office; U.S. DEPARTMENT OF COMMERCE

7. OVERPAYMENT

As to any overpayment made please

OR ☐ Credit to Deposit Account No. _____.

☐ Send refund check.

WARNING: Information on this form may become public. Credit card information should not be included on this form. Provide credit card information and authorization on PTO-2038.

8. SHOWING

The enclosed statement will show that the delay in timely payment of the maintenance fee was unavoidable since reasonable care was taken to ensure that the maintenance fee would be paid timely and that this petition is being filed promptly after the patentee was notified of, or otherwise became aware of, the expiration of the patent. The statement must enumerate the steps taken to ensure timely payment of the maintenance fee, the date and the manner in which the patentee became aware of the expiration of the patent, and the steps taken to file the petition promptly.

9. PETITIONER(S) REQUESTS THAT THE DELAYED PAYMENT OF THE MAINTENANCE FEE BE ACCEPTED AND THE PATENT REINSTATED.

Feb 12, 2001
Date

( )
Telephone Number
no phone

Signature(s) of Petitioner(s)

Patrick Smith
Typed or printed name(s)

2901 Beverly Blvd.
Address

Los Angeles, CA 90057

ENCLOSURES:

☒ Maintenance Fee payment

☐ Statement why maintenance fee was not paid timely

☒ Surcharge

☐ _____

PTO/SB/65 (10-00)
Approved for use through 12/31/2002. OMB 0651-0016
U.S. Patent and Trademark Office; U.S. DEPARTMENT OF COMMERCE

37 CFR 1.378(d) states: "Any petition under this section must be signed by an attorney or agent registered to practice before the Patent and Trademark Office, or by the patentee, the assignee, or other party in interest."

Feb 12, 2001
Date

Signature

Patrick Smith patentee
Typed or printed name

STATEMENT

(In the space below, please provide the showing of unavoidable delay recited in paragraph 8 above.)

The delay in timely payment of the maintenance fee was unavoidably because I was injured in an accident and lost the vision in my left eye due to a blow to the head. My loss of vision was determined to be due to a vascular problem, hemorrage in the eye, or to a neurological problem, compressed nerve. (see enclosed sample of medical reports)

During the time since the accident and continuing up to now I suffer from Vertigo and fail to properly focus or concentrate due to sense of unbalance continually. I failed due to my injury to act in a timely manner, finally realizing the need to do so today. I called the Patent Office and was told what to do.

Sincerely,

Patrick Smith

(Please attach additional sheets if additional space is necessary)

1020 N. Main 124

PATIENT INFORMATION SHEET

PLEASE COMPLETE FORM IN PRINT

ARRIVAL TIME: 11:35

PLEASE NOTE: PATIENTS ARE SEEN ACCORDING TO THE SEVERITY OF THEIR COMPLAINT AND NOT NECESSARILY IN THE ORDER IN WHICH THEY SIGNED IN. THIS DECISION WILL BE MADE BY THE NURSE. THANK YOU FOR YOUR UNDERSTANDING.

PATIENT NAME

LAST	FIRST	MI
SMITH	PATRICK	

BIRTHDATE	AGE	SEX
June 20, 1934	65	Male

FAX RECEIVED
FEB 13 2001
PETITIONS OFFICE

487 34 0635
SOCIAL SECURITY NUMBER

Hit in head in auto accident
REASON YOU ARE HERE TODAY

PRIVATE DOCTOR	MD PHONE #
None	

No Private Doctor ☒ Clinic Patient ☐

ARE YOU TAKING ANY MEDICATIONS? YES ☐ NO ☒
If yes, please list (prescription and non-prescription)

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ☐ NO ☒
If yes, please list

Aspirin ☐ Penicillin ☐ Sulfa ☐

Other:

[redacted]ITH, PATRICK ¶Wed Aug 09, 2000 Page 1
11:18 AM

Discharge Instructions from S. LEVINE, MD
Saint John's Hospital and Health Center Emergency Department

DIZZINESS:
Dizziness is a common problem that has many causes. Most illnesses and many medications can cause dizziness along with other symptoms. Even It may at times signal a problem with the heart or circulation. many minor diseases, such as viral infections, often have dizziness as one of the main symptoms.

Vertigo is a kind of dizziness that gives the sensation that you or your surroundings are spinning. This usually involves the balance centers in the inner ear - and is often caused by a virus infection. In the elderly, poor circulation to the brain will often cause vertigo.

The actual cause of an episode of dizziness is often very hard to pinpoint. Your evaluation today indicates that a serious cause is not likely. You should remain at rest until you are feeling better. If your symptoms persist or worsen, or if other symptoms develop, you will need follow-up with your doctor or the Emergency Department.

NOTIFY YOUR DOCTOR or return here in case of the following:
- Dizziness is worsening or any fainting.
- Chest pain or discomfort of any kind, or irregular heartbeat.
- Abdominal or back pain that is worsening or changing in location.
- Prolonged or high fever.
- Severe or worsening headache.
- Change in mental status - too sleepy, confused, short of breath, irritable, slurred speech, weakness, or difficulty walking.
- Repeated vomiting or inability to retain fluids.

OTHER INSTRUCTIONS:
YOU WERE EVALUATED IN THE EMERGENCY ROOM FOR DIZZINESS BY DR. S. LEVINE, THE CARDIOLOGIST. FOLLOW UP WITH HIM AT HIS OFFICE TOMORROW AS DIRECTED. RETURN SOONER TO THE ER FOR ANY CHANGE IN OR WORSENING OF SYMPTOMS

If you have more questions or problems with your medical condition or the treatment, see your doctor or call us at number (310) 829-8212.

My signature indicates that I understand, and have received a copy of, the above instructions.

_____

Bes vailable Copy

VN# 3023

034/195-39-54 3
SMITH, PATRICK
M 66 06/20/1934 SML
08/30/00 ODOPC

195-39-54 3023 2

FAX RECEIVED
FEB 13 2001
PETITIONS OFFICE

(Medical)

UCLA HOSPITAL & CLINICS
CONSULTATION REQUEST

PATIENT'S FLOOR	PATIENT'S ROOM	SERVICE

REQUESTING PHYSICIAN: Lynn Gordon

REQUESTING PHYSICIAN'S TELEPHONE NUMBER: page 09701

NAME OF CONSULTING PHYSICIAN REQUESTED: Any Neurology clinic

PHYSICIAN REQUIRED IS: ☐ ATTENDING PRIVATE ☐ PERSONAL PRIVATE

DATE OF CONSULTATION REQUEST: 8/30/00

CONSULTATION RE[QUESTED] BY THIS DATE: ASAP

MEDICINE	PEDIATRICS	SURGERY	OTHER SPECIALTIES
☐ GENERAL MEDICINE	☐ GENERAL PEDS	☐ GENERAL SURGERY	☐ ANESTHESIA
☐ CARDIOLOGY	☐ PEDS CARDIOLOGY	☐ GEN., VASCULAR & PED. SURGERY	☐ AUDIOLOGY & SPEECH
☐ CLIN. IMMUNOLOGY-ALLERGY	☐ PEDS ENDOCRINOLOGY	☐ GEN. & ABDOMINAL SURGERY	☐ DENTISTRY-INPATIENT
☐ CLIN. PHARMACOLOGY	☐ PEDS GASTROENTEROLOGY	☐ ONCOLOGICAL SURGERY	☐ DENTISTRY-OUTPATIE[NT]
☐ DERMATOLOGY	☐ PEDS GENETICS	☐ HEAD & NECK (OTOLARYNGOLOGY)	☑ NEUROLOGY
☐ ENDOCRINOLOGY-METABOLISM	☐ PEDS HEMATOLOGY	☐ NEUROSURGERY	☐ OB/GYN
☐ GASTROENTEROLOGY	☐ PEDS IMMUNOLOGY	☐ ORAL & MAXILLOFACIAL SURGERY	OCCUPATIONAL THERA[PY] (use their request form no.
☐ GENETICS	☐ PEDS INFECTIOUS DISEASE	☐ ORTHOPEDICS	☐ OPHTHALMOLOGY
☐ HEMATOLOGY-ONCOLOGY	☐ PEDS NEPHROLOGY	☐ PLASTIC SURGERY	☐ PATHOLOGY
☐ INFECTIOUS DISEASE	☐ PEDS NEUROLOGY	☐ THORACIC SURGERY	PHYSICAL THERAPY (use their request form no.
☐ NEPHROLOGY-HYPERTENSION	☐ CHILD DEVELOPMENT	☐ UROLOGY	☐ PSYCHIATRY (CALL 502
☐ PULMONARY	☐ ______	☐ ______	☐ PROSTHETICS
☐ REHABILITATION MEDICINE			☐ RADIOLOGY-DIAGNOST[IC]
☐ RHEUMATOLOGY-ARTHRITIS			☐ RADIOLOGY-NUCLEAR
☐ ______			☐ RADIOLOGY-THER (CAL
			☐ SOCIAL SERVICE

THIS CONSULTATION IS ☐ ROUTINE ☐ URGENT

STATE THE PROBLEM: 66 yo ♂ s/p Left supraorbital trauma w/ accident c/o dizzy, ↑ episode LOC → UCLA ER pt signed out AMA! Pt requested to have MRI [in cedars since ER and lightheaded put off that ...] not done, continues to have dizziness.

Appt: 10/24/00, Tues 3
DR DOMINICK

SEND REQUEST TO HOUSE STAFF ... CONSULTATIONS ... (...APPROPRIATE NUMBER)

195-39-54 3 VN# 3023
TH, PATRICK
66 06/20/1934 SML
08/30/00 ODOPC
195-39-54 3023 2

UNIVERSITY OPHTHALMOI
ASSOCIATES
JULES STEIN EYE INSTITU
100 Stein Plaza, UCLA
First Floor
Box 957000
Los Angeles, CA 90095-7000
(310) 825-3090

Follow-up Examination

FAX RECEIVED
FEB 1 3 2001
PETITIONS OFFICE

OT

Patient Name:

Date: 8-30-00

Age and Sex: 66 yo m

Date of Prior Examination: 9-17-9

Contact Lens Hx:

Average Wearing Time:

Wearing Time Today:

Contact Lens Solutions:

Medications: Ø gtts. NKDA alancoline - sto d...

INTERVAL HISTORY:

s/p KPE/PCIOL OD

Pt was involved in a car accident last 12/1/99 & loss vision in OS car door struck by 2nd vehicle and door slammed back on OS (L) orbit - bruising above superior orbital ridge. Lost VA OS immediately → dizzy → cedars since 0 told of hyphema OS → Dr. Kazemi neurology TBH. MRI performed or lobectomy → Not performed 2° financial constraints Insurance Co would not pay. Vision never reco... told of probable compressed nerve. did not return for treatment - recommend Rx. 1 month ago → LOC in pharmacy taken to ER at left ER AMA. Fko Cedars - ER No MRI or CT since accident

VISUAL ACUITY:

(sc) RE 20/60 PH ____ sc Near ____

cc LE CF 6" PH ____ cc Near ____

WEARING PRESCRIPTION:

RE ____

LE ____

Add ____

REFRACTION:

Manifest: Dist: Add: Near:

RE -1.00 VA 20/20-2 +2.50 VA 20/20-

LE Balance VA ____ VA ____

Over-Refraction: +0.50 pl 20/80 ?

RE ____ VA ____ 7 +1 - ... (APD OS

LE ____ VA ____

Cycloplegic:

RE ____ VA ____

LE ____ VA ____

KERATOMETRY:

RE ____

LE ____

SLIT LAMP EXAMINATION RE LE

	RE	LE	
Eyelids/lashes			☑ normal OU
Conjunctive			☑ clear OU
Cornea			☑ clear OU
Anterior Chamber			☑ deep & quiet O
Iris			☐ normal OU
Lens	PCIOL	2+ NS 1+ cortical PSC OS	☐ clear OU

INTRAOCULAR PRESSURE: ✓ Applanation ____ Pneumotonometer ____ Tono

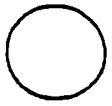
RE 12 mm Hg LE 14 mm Hg Time 9 STA

DILATED EXAMINATION: (Agent: M1 M1/2 C1 C1/2 CM N2.5 N10 A1)

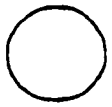
Time: 10:45

Optic Nerve Heads

RE

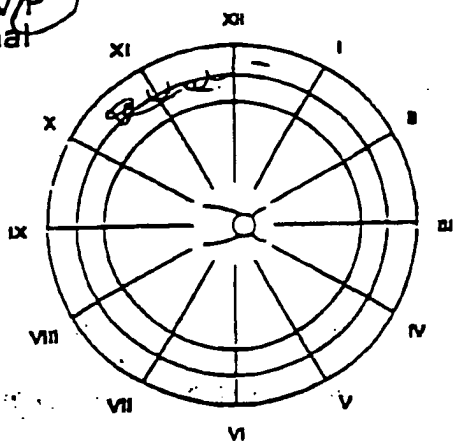


LE

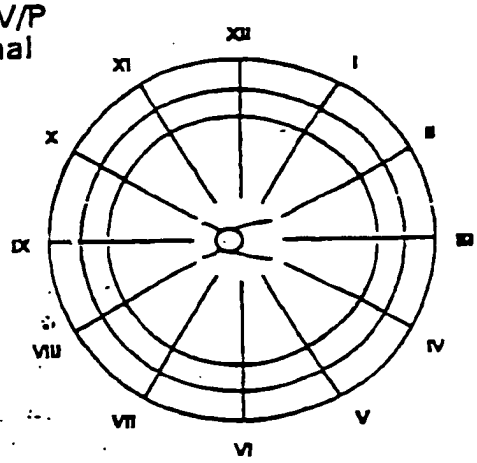


cup/disc

☑ D/M/N/P normal mild Δ's



☑ D/M/N/P normal



IMPRESSION:

A/ s/p trauma – request VF
① ? pos to RAPD but doubt
② cataract if VF OK consider CE
③ dizzy – refer to neurology.

ATTENDING:

RECOMMENDATIONS:

PHYSICIANS CONTACTED: ☐ Letter ☐ Telephone

Follow-up:

Signature: Gordon

Supervising Faculty: _____

Single Field Analysis

Eye: Right

Name: SMITH,PATRICK ID: 1953554 DOB: 06-20-1934

Central 30-2 Threshold Test

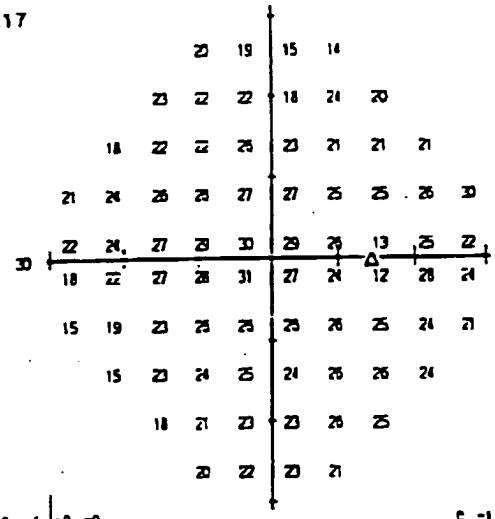
Fixation Monitor: Blindspot
Fixation Target: Central
Fixation Losses: 8/19
False POS Errors: 1 %
False NEG Errors: 0 %
Test Duration: 08:17

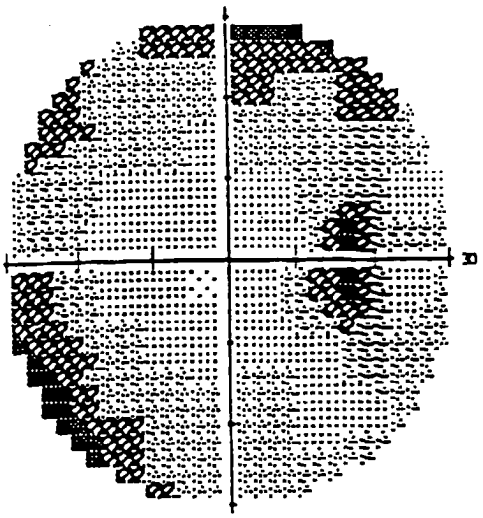
Fovea: 33 dB

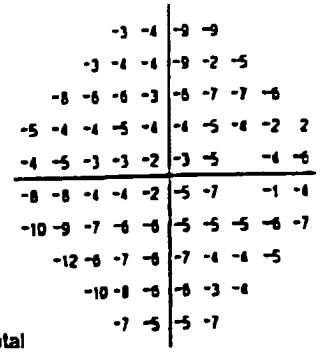
Stimulus: III, White
Background: 31.5 ASB
Strategy: SITA-Standard

Pupil Diameter:
Visual Acuity:
RX: +2.25 DS DC X

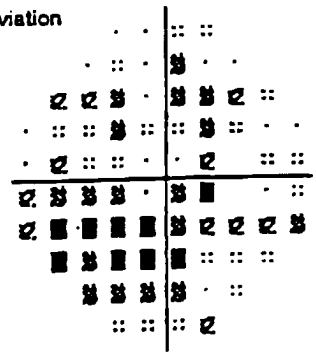
Date: 09-01-2000
Time: 2:39 PM
Age: 66

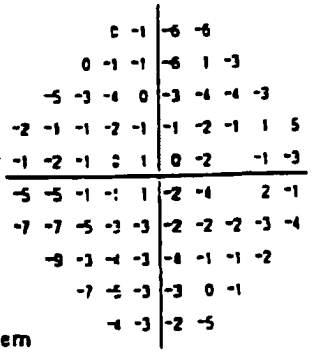




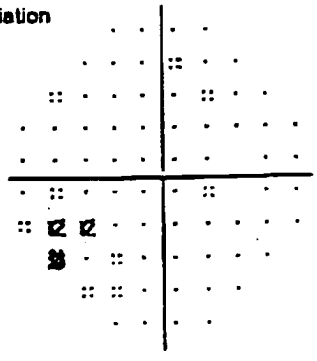


Total Deviation





Pattern Deviation



:: < 5%
▨ < 2%
▩ < 1%
■ < 0.5%

GHT
General Reduction of Sensitivity

MD -5.04 dB P < 0.5%
PSD 2.42 dB P < 10%

JULES STEIN EYE INSTITUTE / U.C.L.A.
GLAUCOMA DIVISION, 2ND FLOOR
VISUAL FIELD LAB, ROOM 2
100 STEIN PLAZA, L.A.,CA 90095
310-794-9442 FAX 310-794-5541.

HFA II 750-3877-Rev. A10.2

Field Analysis — Eye: Left

Name: SMITH,PATRICK — ID: 1953554 — DOB: 06-20-1934

Central 30-2 Threshold Test

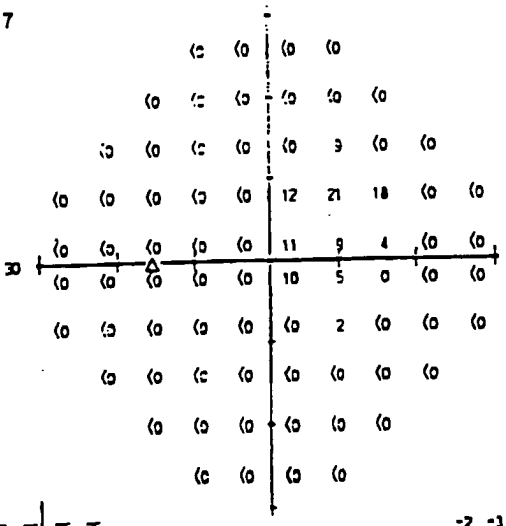
Fixation Monitor: Blindspot
Fixation Target: Central
Fixation Losses: 0/15
False POS Errors: 0 %
False NEG Errors: 99 %
Test Duration: 06:27

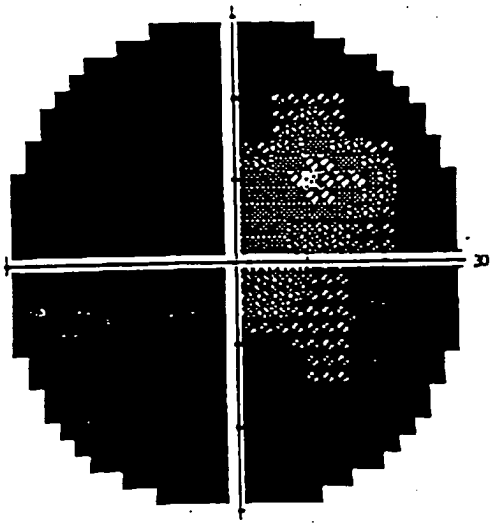
Fovea: 19 dB

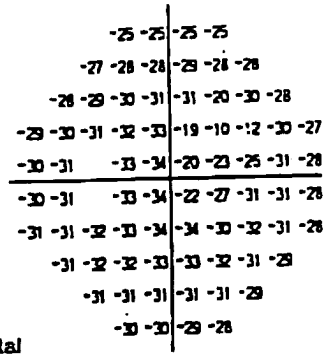
Stimulus: III, White
Background: 31.5 ASB
Strategy: SITA-Standard

Pupil Diameter:
Visual Acuity:
RX: +3.75 DS DC X

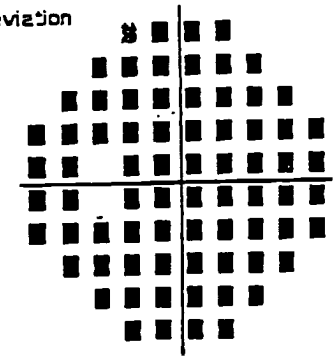
Date: 09-01-2000
Time: 2:51 PM
Age: 66

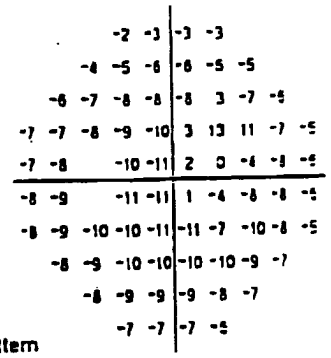




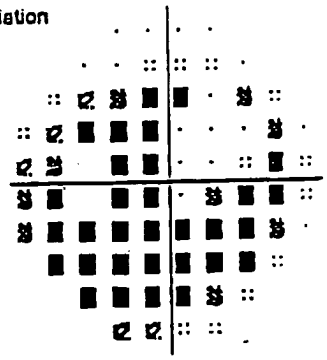


Total Deviation





Pattern Deviation



:: < 5%
▨ < 2%
▩ < 1%
■ < 0.5%

GHT
Outside normal limits

MD -29.00 dB P < 0.5%
PSD 6.05 dB P < 0.5%

JULES STEIN EYE INSTITUTE / U.C.L.A.
GLAUCOMA DIVISION, 2ND FLOOR
VISUAL FIELD LAB, ROOM 2
100 STEIN PLAZA, L.A.,CA 90095
310-794-9442 FAX 310-794-5541.

036/195-39-54 3 07/27/00
SMITH, PATRICK
M 66 06/20/1934 SML

VN# 3022

UCLA MEDICAL CENTER

LEAVING HOSPITAL AGAINST MEDICAL ADVICE

INSTRUCTIONS: Complete all blanks. Strike words that do not apply. The physician completes the "Advice" section. The patient signs the "Release" section.

Patrick Smith
PATIENT'S NAME

PERSON BEING ADVISED

PHYSICIAN ADVISING

FAX RECEIVED
FEB 13 2001
PETITIONS OFFICE

Care being refused (specify and describe): CT Scan Head, Syncope Workup.

Risks/complications that can/will result from refusal of the above described advised care (specify and describe) Include: ~~Loss~~ Death, Irreversible brain injury

I certify that, to the best of my belief, the patient understands the risks of refusing care.

SIGNATURE OF PHYSICIAN ADVISING PATIENT/RESPONSIBLE PARTY

SIGNATURE OF TRANSLATOR (IF APPLICABLE)

7/27/00
DATE AND TIME OF ADVICE ☐ AM ☐ PM

I, Patrick Smith acknowledge that on 7/27/00

Dr. Talhar advised me of the above stated risks and/or complication which could or would arise from refusal of the above advised medical care. I understand the risks and/or complication. It is still my desire to refuse the advised medical care stated above.

I do hereby release UCLA Medical Center, its agents, employees and physicians from all liability resulting from an adverse medical condition(s) caused by my refusal of the above advised medical care.

Patrick Smith
SIGNATURE OF PATIENT/RESPONSIBLE PARTY

SIGNATURE OF TRANSLATOR (IF APPLICABLE)

DATE AND TIME ☐ AM ☐ PM

On _____ DATE, this patient/responsible party _____

- ☐ refused the above stated advised medical care.
- ☐ left UCLA Medical Center without signing the above release.
- ☐ left UCLA Medical Center without full medical advice.

M.D./R.N. SIGNATURE

7/27/00
DATE AND TIME ☐ AM ☒ PM

Refer to N.S. Policy No. 202

02/13/01 13:02 FAX Best Available Copy 016

☐ FRIEND ☐ POLICE ☐ PARAMEDICS ☐ OTHER

DISCUSSED WITH PMD:

036/195-39-54 3 07/27/00
SMITH, PATRICK
M 66 06/20/1934 SML

CONSULT PAGED: @:
CONTACTED: DR. @: ☐ TRANSLATOR REQUIRED

☐ RN ASSESSMENT REVIEWED TELEMETRY STRIP: NSR 76 s̄ ectopy

CT/UTZ: Left AMA

VN# 3022

RUA:
PREGNANCY:
ABG:

PT: CK: Ca: AST/ALT:
INR: MB: Mg: Alk Phos:
PTT: TROPONIN: Phos: T. Bili:

X-RAYS:

☐ REVIEWED WITH RADIOLOGIST

ECG: NSR 74, nl

OTHER:

FAX RECEIVED

☐ PRIOR ECG REVIEWED. ☐ NO SIGNIFICANT CHANGE SINCE: ☐ OTHER:

FEB 13 2001

☐ PRIOR LABS REVIEWED WHICH SHOWED:

PETITIONS OFFICE

☐ PRIOR MED RECORDS REVIEWED WHICH SHOWED:

LACERATIONS			DISTAL ROM	DISTAL SENSORY	DISTAL CIRCULATION	TENDONS	SUTURE TYPE	PREPARATION	ANESTHESIA
LENGTH CM	LOCATION	☐ SIMPLE ☐ LOCAL ☐ CMPLX ☐ DIGITAL BLOCK	☐ WNL	☐ WNL	☐ WNL	☐ WNL		☐ IRRIGATION	☐ LIDO ___% ☐
LENGTH CM	LOCATION	☐ SIMPLE ☐ LOCAL ☐ CMPLX ☐ DIGITAL BLOCK	☐ WNL	☐ WNL	☐ WNL	☐ WNL		☐ IRRIGATION	☐ LIDO ___% ☐

☐ I was present with Dr. ________ during the key portion of the ________ procedure performed.

X ________

☐ I was personally present and supervised the entire ________ procedure performed by Dr. ________. X ________

☐ See procedure note
☐ Laceration repair
☐ Endotracheal Intubation ☐ RSI
☐ Conscious sedation
☐ LP ☐ Central line
☐ Other

EMERGENCY DEPARTMENT COURSE AND DECISION MAKING - RE-EVALUATIONS AND DIFFERENTIAL DIAGNOSIS

23:48 Wants to leave AMA - doesn't want other W/U. risks explained. AMA signed

ATTENDING NOTE: I have examined the patient and agree with the findings and treatment plan of Dr. TAKHAR

Syncope c̄ fall, hit head - unsure how long out. H/o 3-4 syncopal episodes since head injury in MVA last year - lost ⓒ vision, ā accident - ā CT scans, seeing neuro optomol. ō med probs. Atypical CP in past ō ⊖ W/U. Syncopal W/U opened x @ ... Pt - AMA, NAD, ⊕x3, GCS 15 CrN's normal ō mid c-tender chest clear sym strength plan: ō PMD to ..., ... W/U again → CT head, CBC, chem, EKG

Dx: SYNCOPE

DISCHARGE IMPRESSION:
1. Syncope
2.
3.
4.

DISCHARGE PLAN:
1. Pt. left AMA.
2.
3.
4.

CONDITION ON DISCHARGE
☐ GOOD ☐ AMBULATORY
☑ FAIR ☐ WHEELCHAIR
☐ CRITICAL ☐ CRUTCHES

DISPOSITION
☐ HOME ☐ ADMIT ☐ EXPIRED
☐ LEFT WITHOUT BEING SEEN
☑ LEFT AGAINST MEDICAL ADVICE

☐ STABLE FOR TRANSFER TO ________ VIA ☐ EMT ☐ PARAMEDIC ACCEPTANCE NO.:

☐ CRITICAL CARE TIME: MINS.

☐ COMPLETE CHART

☐ SIGNED OUT TO: TIME:

SIGNATURE #1 MD SIGNATURE #2 MD ATTENDING SIGNATURE MD SEE NOTE ☐

PRINT NAME Takhar PRINT NAME PRINT NAME Gonzales DICTATED ☐

Eyes Examined • Contacts • Glasses
Emergency Service

10724 Washington Blvd.
Culver City, CA 90230

(213) 870-2848
(310) 559-0500
FAX (310) 559-4009

3/17/00

re: Smith, Patricia
8/20/34

Visual Acuity OS (left eye) today is 20/200+1 best corrected. Pin hole visual acuity gives minimal improvement to 2/100-4/4. Based on patient provided form, this is a 25% Reduction

Sincerely,

M. Yan

2.- VISION

2.1- LOSS OF SIGHT WITH COSMETIC EFFECT

Enucleation (or evisceration) of one eye:

2.121	With ability to wear artificial eye	30%
2.131	With inability to wear artificial eye	35%

Loss of sight of one eye[5]

2.141	With marked blemish that would afford an observer evidence of the loss	30%

2.2- LOSS OF SIGHT

2.211	Loss of sight of one eye with no blemish that would afford an observer evidence of the loss	25%
2.213	Loss of both eyes or the sight thereof	100%

4 Consideration may be given to such factors as: ptosis of eyelid, entropion (turning in of the lid), ectropion (turning out of the lid), lacrimation, photophobia, chronic conjunctivitis, enlarged pupil, coloboma (irregular pupil), blurring, scarring of the eyeball.

5 In case of loss of sight with blemish, the standard will vary between the ratings for disabilities 2.141 and 2.211, depending on the degree of the disfigurement.

2.3 REDUCTION OF VISION[6]

2.311 Reduction of vision, one eye to:[7]

Distance (Snellen) as index	Near (Jaeger) as index	
20/20	1,2,3,4	0%
20/30	5	3%
20/40		5%
20/50		7%
20/60		9%
20/70		11%
20/80		13%
20/100	6	16%
20/125	7,8	19%
20/150		22%
20/200	9	25%

2.313 Reduction of vision of both eyes[8]

2.4 APHAKIA (LOSS OF NATURAL LENS)[9]

One eye, correction of visual acuity with spectacle lens to:

2.411	20/25 or better	20%
2.421	20/30 to better than 20/50	21%

6 Ratings are based on vision with best practicable correction.

7 When reduction of distance and near vision are both present, use index which produces the higher standard rating.

8 To obtain rating for bilateral reduction of vision, see Table 1C "Eyes - Bilateral Reduction of Vision", on page 7-3.

9 In cases of aphakia with practicable correction by means other than spectacle lens, the standard rating shall be based on disability found under reduction of vision (disability 2.3) plus 1/2 the difference between disabilities 2.4 and 2.3.

) 859-0290

ALI A. KASHANI, M.D.
DEIPLOMATE. AMERICAN BOARD OF OPHTHALMOLOGY
436 NOTRH ROXBURY DRIVE SUITE 114
BEVERLY HILLS, CALIFORNIA 90210
U.S.A

ember 14, 1999

Mr. Smith Patrick

Whom It May Concern:

se be advised that Mr. Patrick Smith was seen at our office for his eye condition and he paid
).00 for today's visit. He needs to have three more follow up visits with me, and a visual
test. Mr. Smith needs to pay $600 for the follow up visits and required tests. Mr. Smith has
seen at Cedars-Sinai Hospital before, and he was reportedly diagnosed with left anterior
nber hemorrhage. His eye pressure is normal right now but he needs follow up. He may also
ire B-scan.

nk you for your attention. Please do not hesitate to call us if you have any questions.

erely Yours,

A. Kashani, M.D.

STEPHEN B. FIERSTIEN, M.D.
A PROFESSIONAL CORPORATION
BEVERLY HILLS IMAGING MEDICAL CENTER
145 SOUTH DOHENY DRIVE
BEVERLY HILLS, CALIFORNIA 90211
TELEPHONE (310) 550-5858
FAX (310) 550-5775

DIAGNOSTIC RADIOLOGY

January 5, 2000

Dear Mr. Smith,

Dr. Ali Kashani has asked our office to schedule you for an MRI Brain scan and an MRI Orbit scan. I understand that there are financial reasons that would prevent you from having these necessary exams. I have agreed, at Dr. Kashani's request, to accept a cash payment of $1,500.00 dollars, paid at the time of service, as payment in full. I hope we can be of service to you.

Sincerely,

Paula Nickolas

aula Nickolas
ffice Manager

U C L A H E A L T H C A R E
UCLA MEDICAL CENTER
PATIENT STATEMENT OF ACCOUNT - DETAIL

PATIENT NAME: SMITH, PATRICK

ACCOUNT NBR: 000073088-3022
BILLING PERIOD: 07/29/00 09/01/00

BILL TO
PATRICK SMITH
2901 BEVERLY BLVD
LOS ANGELES CA 90057

SRV DATE	REF NBR	DESCRIPTION	
07/27/00	15400023	CHLORIDE, SERUM	33.0(
07/27/00	15400029	CO2 CONTENT, SERUM	33.0(
07/27/00	15400031	CREATININE	33.0(
07/27/00	15400042	GLUCOSE	33.0(
07/27/00	15400072	POTASSIUM	33.0(
07/27/00	15400079	SODIUM	33.0(
07/27/00	15400086	UREA NITROGEN	59.0(
07/27/00	15400266	CBC & PLT & DIFF	36.0(
07/27/00	15400380	PT	49.2(
07/27/00	15400353	APTT	243.0(
07/27/00	28900027	ER LEVEL IV	8.00
07/27/00	28900631	ELECTRODES	142.0(
07/27/00	28900193	INTRAVENOUS STARTS	

-- WE HAVE BILLED THE FOLLOWING INSURANCE(S) --
07/29/00 - 08/31/00
MEDI-CAL

REMIT TO
UCLA HEALTHCARE
10920 WILSHIRE BLVD
SUITE 1600
LOS ANGELES CA 90024

BEGINNING BALANCE	0.00
NEW CHARGES/ADJUSTMENTS	768.20
NEW PAYMENTS/CREDITS	0.00
CURRENT ACCOUNT BALANCE	768.20

MAKE CHECK PAYABLE TO: UCLA HEALTHCARE

IF YOU HAVE ANY QUESTIONS CONCERNING THIS STATEMENT PLEASE CONTACT:
CUSTOMER SERVICE PHONE: (310) 825-8021

All labs, EKGs, plain x-rays, oxygen saturations and rhythm strips are interpreted by the ED physician unless otherwise specified

Pulse Ox: SO2 ____ %
Rhythm strip: Rate 77 NSR Atrial SVT
Occasional / frequent PACs / PVCs
Sinus bradycardia / tachycardia Other
EKG: Rate 75 NSR Axis wnl Intervals wnl
Sinus bradycardia / tachycardia Afib Aflutter SVT
Vtach LBBB RBBB LAFB Q's LVH
NSSTTA's PRWP Occasional / frequent PACs / PVCs
ST elevation ____ mm Leads
ST depression ____ mm Leads

Dx: Normal EKG Borderline EKG Abnormal EKG
CXR: normal heart size CM CHF Infiltrate
NO INFILTRATES
Dx: Normal CXR Borderline CXR Abnormal CXR

Laboratory and radiographic results:

CK-81
TROP <0.15

8.1 / 14.4 / 267,000 / 43

140 | 103 | 18/115
3.9 | 26 | 0.9

Ca-8.9

ED course: Reassessments Consultations Procedure note Prior records reviewed

FAX RECEIVED
FEB 13 2001
PETITIONS OFFICE

Admitted to ED observation [DATE/TIME] EDMD ____ Observation note (*Re-exam required*) Dx: ____

Procedures: Central line Chest tube CPR ET intubation FB removal Nerve block I&D LP Slit lamp exam Restraints Other ____

Laceration repair: Length ____ cm
Simple / Complex Anesthesia ____
Irrigated w/NS Suture ____
Type ____ Number ____

Fracture(Fx)/Dislocation(D) care:
Bone Fx'd / D ____
Fx: Displaced / Nondisplaced
Initial treatment and stabilization
Treatment: Application of Sling / Splint

Conscious Sedation: Reason: ____
Sedation/Analgesic agent(s) ____
Post-procedure evaluation: [TIME]
Awake, alert, ambulatory Vital signs stable
Conscious sedation protocol followed-see nursing record

Clinical Impression: 1] ACUTE DIZZINESS
2] GASTROESOPHAGEAL REFLUX DISEASE
3] ____
4] ____
5] ____

ACI: Abdominal pain Ankle sprain Asthma
Back pain Chest pain Diarrhea Fever Headache
Head injury UTI Viral syndrome Vomiting Wound
Wound ✓ ____ days Suture removal ____ days
Follow up in ____ with ____
Do not drive while taking ____
☑ RTED or PMD for a worsening of symptoms
☑ Instructions explained & questions answered
Left AMA Risks explained Pt competent

F/U AT UCLA-NEURO
TOMORROW
AS SCHEDULED

Disposition: Home Left AMA Admitted by Dr. ____ To ____
Transferred to ____ By ____ No. ____ Accepted by Dr. ____
Stable for transfer Unstable for transfer Transferred to a higher level of care
Condition on disposition or transfer: Stable Unstable Expired
CRITICAL CARE TIME ____ minutes

ED PA/MD Discussed with Dr. ____ Signed out to Dr. ____
History and physical exam performed and clinical decisions made by Dr. ____
1] [illegible] 3]

ADDRESSOGRAPH

Saint John's Health Center
Santa Monica, CA 90404

SMITH, PATRICK
#0203154 L015772940 05/21/58
HEILPERN, ALAN M.

EMERGENCY DEPARTMENT SUMMARY

09/06/00 M 56 REG ER

WHITE - CHART YELLOW - BILLING PINK - DEPARTMENT

Public Service Agency

REPORT OF VISION EXAMINATION

(Form valid for 6 months from examination date)

91

APPLICANT COMPLETES THIS SECTION

DRIVER LICENSE NUMBER	DATE OF BIRTH (MO., DAY, YR.)	HOME TELEPHONE NUMBER
P0440873	6-20-34	

NAME (FIRST, MIDDLE, LAST): Patrick Smith

RESIDENCE ADDRESS	CITY	STATE	ZIP CODE
2901 Beverly Blvd.	Los Angeles	Ca.	90057

APPLICATION DATE	FIELD OFFICE
2-3-00	Santa Monica

I authorize the vision specialist conducting this examination to provide the Department of Motor Vehicles (DMV) with the following information for its confidential use (CVC1808.5) in evaluating my ability to safely operate a motor vehicle.

FAX RECEIVED

APPLICANT'S SIGNATURE | DATE

FEB 13 2001

PETITIONS OFFICE

OPHTHALMOLOGIST OR OPTOMETRIST COMPLETES THIS SECTION

REFRACTION

HAVE NEW DISTANCE LENSES BEEN PRESCRIBED AND FITTED?
[X] Yes [ ] No If yes: [ ] Glasses [ ] Contact Lenses [ ] Bioptic Telescope

DATE NEW LENSES WERE PRESCRIBED: 2-9-2000

DISTANCE LENSES WERE PRESCRIBED AND FITTED, IS THIS THE BEST POSSIBLE CORRECTION? IF NO, EXPLAIN.
[X] Yes [ ] No History of Recent Team C.E. Refractive Evaluation

A BIOPTIC TELESCOPIC LENS WAS PRESCRIBED, IS IT
[ ] Galilean [ ] Keplerian [ ] Periscope/Keplerian [ ] Other

DID YOUR PATIENT RECEIVE TRAINING IN USING THE BIOPTIC TELESCOPIC LENS?
[ ] Yes [ ] No

IF YES, WAS DRIVING INCLUDED IN THE TRAINING?
[ ] Yes [ ] No

VISUAL ACUITY

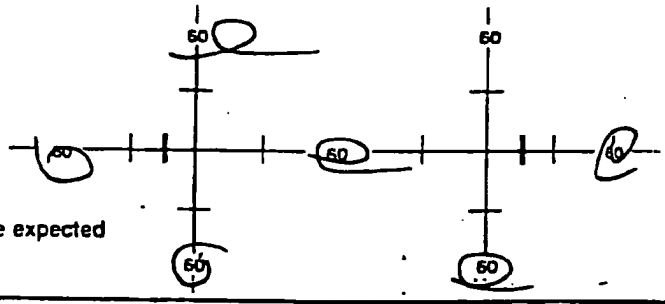
DMV MEASUREMENT (ORTHORATER OR EQUIVALENT)	Both Eyes	Right Eye	Left Eye
Without Lenses	T/ 20/40	T/ 20/40	T/
With Lenses	T/	T/	T/

CLINICAL MEASUREMENT	Both Eyes	Right Eye	Left Eye
Without Lenses	20/ 50	20/ 50	20/ 100
With Correction	20/ 25	20/ 25	20/ 100

VISUAL FIELDS A full visual field examination extending at least 60°, using a standard test object such as a 10mm white mark, must be performed if any condition exists which might affect peripheral vision. Show the approximate peripheral extent and any scotomas in the diagram below.

LEFT EYE

Extent:
Left 180
Right 90
Up 180
Down 90



RIGHT EYE

Extent:
Left 180
Right 90
Up 180
Down 90

[ ] No condition exists that would be expected to impair visual fields.
[ ] Diagram is attached.

DIAGNOSIS Please indicate the severity of the vision condition by placing a number 1, 2, or 3 in the box representing the affected eye(s) (1 = mild 2 = moderate 3 = severe). Definitions of mild, moderate, and severe, for each condition can be obtained from DMV. If your patient has Hemianopia or Pseudophakia, check the box representing the affected eye.

	R	L		R	L		R	L		R	L		R	L
Amblyopia			Aphakia			Astigmatism	1	3	Cataract			Diplopia			Glaucoma		
Hyperopia			Hemianopia*			Keratoconus			Myopia			Nystagmus			Pseudophakia		
Scotoma			Decreased Peripheral Vision	1	2	Diabetic Retinopathy			Macular Degeneration			Retinal Detachment			Strabismus		
Retinitis Pigmentosa																	
Monocular			Could the condition in the blind eye affect the fellow eye in the future? [ ] Yes [ ] No														
Other	1	3	When was the monocular vision diagnosed? Retinal Full Work-up Not Including Scan of L.E.														

*Hemianopia: Please identify the quadrants affected on the chart above.

PROGNOSIS

[ ] Stable [ ] Potentially progressive [X] Improvement possible

PLEASE ESTIMATE HOW SOON YOUR PATIENT'S VISION SHOULD BE REEVALUATED. [ ] 6 mos. [ ] 1 year [ ] 2 years [ ] 4 years [ ] Other 6 mos. Retest for Med. Eval. CE

ADVICE

WHAT ADVICE HAVE YOU GIVEN YOUR PATIENT ABOUT DRIVING?
[ ] Drive in familiar areas only [ ] No night driving [ ] Do not drive [ ] No advice given [ ] Other

PRINTED NAME	SIGNATURE	M.D. OR O.D. LICENSE NUMBER	DATE OF EXAM
Laurice Friedman OD	X	4423	2-2-00

ADDRESS	CITY	ZIP CODE	TELEPHONE NUMBER
10724 Washington Blvd			(310) 559 0500

DL 62 (REV. 12/97)